Summary of the June 16, 2003 System Leadership Council Meeting

The following Council members attended this meeting.

Janet Areson	Nita Grignol	Julie A. Stanley, J.D.
H. Lynn Chenault	Larry L. Latham, Ph.D.	James W. Stewart, III
Charline A. Davidson	George W. Pratt, Ed.D.	Frank L. Tetrick, III
Judy Dudley	Raymond R. Ratke	James A. Thur, M.P.H.
Paul R. Gilding	James S. Reinhard, M.D.	Joy Yeh, Ph.D.

Martha Adams, Shirley Ricks, Wendi Wilson-John, Jeff Harlow (via telephone), Grace Sheu, and Martha Mead also attended the meeting. Rosemarie Bonacum attended for Jerry Deans.

1. **Agenda and Meeting Summary:** The Council accepted the summary of its April 28 meeting and adopted the proposed agenda. Ray Ratke reported that Dr. Evans called to say that the two-week pass-to-discharge issue needs to be addressed at the next Council meeting. Dr. Evans indicated that Dr. Everett, the Inspector General, feels that two weeks is too long. The Council agreed to defer further discussion about the pass-to-discharge to its next meeting. Larry Latham is leaving Virginia, and Dr. Jack Barber, Director of Western State Hospital, will take his place on the Council.

2. **Part C Contact and iTOTS**

- Shirley Ricks distributed and reviewed an overview of the Part C program and a copy of the current Part C contract used by the Department, the lead state agency for Part C. She focused on the information that Local Interagency Coordinating Councils (LICCs) and their fiscal agents submit to the Department. She noted that the contract was reviewed and approved by the Office of the Attorney General for use in FY 2004, although there are concerns about it.
- For example, LICCs have no statutory authority to contract with the Department, which is why it contracts with LICC fiscal agents. The Department is convening a committee to address Part C issues. It will include CSB Executive Directors, CSB Mental Retardation Directors, LICC Coordinators, participating state agency representatives, and parents. Shirley asked for volunteers to serve on the committee. George Pratt agreed to give names to her next week.
- Shirley noted that the Part C infrastructure has been in place for 10 years, and some changes in it may be needed. She identified a couple of potential alternatives. The LICC fiscal agent could be authorized by statute to sign the contract, or the Code of Virginia could identify a local lead agency with which the Department could contract. Currently, 33 CSBs serve as LICC fiscal agents, and other organizations serve as fiscal agents for the remaining seven LICCs.
- The Department hopes to address any concerns or changes by January 1, 2004. Any proposed changes requiring statutory changes would take effect July 1, 2004. Martha Mead mentioned that any legislative proposals for the 2004 General Assembly would need to be developed by September 1 for consideration by the Secretary and Governor.
- Shirley introduced iTOTS, the on-line infant and toddler tracking system that produces the December 1 child count and quarterly reports for the Part C Office. The Department has contracted with Old Dominion University (ODU) to develop and maintain this system. Wendi Wilson-John from ODU circulated and discussed handouts describing iTOTS.
- Phase One of iTOTS is a web-based system, but it does not track services for children who are not eligible for Part C. iTOTS uses real-time data and produces more accurate information.
- Phase Two of iTOTS is being developed because more information is needed about Part C services than the Community Consumer Submission would provide. It was noted that Phase Two is controversial with many CSBs, because it will require a lot of data entry by LICC Part C Coordinators. ODU has been working with a group of MR Directors and Part C Coordinators on Phase Two for one and a half years. This group is now identifying required and non-required data elements. Phase Two also will contain an option to automate the ISFP. The requirements document for Phase Two was recently delivered to the software developer.

- Jeff Harlow discussed iTOTS and the effort to capture information on all Part C babies. He noted that Part C reaches far beyond CSB services, and the system has experienced difficulties in tracking non-CSB babies. Phase 2 will allow capturing this information from private providers.
- He indicated that MIMS and the MR Family Survey will be integrated through iTOTS by mapping information from it to those instruments. Part C is a somewhat fragmented system, and babies are being served now who are not known to the system. Dialogue is beginning with other systems that serve Part C babies (e.g. the Department of Education and hospitals) about an automated referral system.
- Shirley noted that the field is concerned about the iTOTS workload. Jeff responded that iTOTS is very flexible and has very few required fields. Localities would have the option of using it as a comprehensive management tool or just as a means to collect required data. He noted that they are talking with three major CSB vendors (CMHC, Anasazi, and BTI) about developing an export function to reduce workload. The export file would be part of iTOTS, available when Phase Two is launched.
- Concerns were expressed about HIPAA ramifications. Jeff replied that, since this is a web-based application, data is not transferred; instead, the Part C Office accesses data through the web. He assured the Council that the vendor being used by ODU is HIPAA compliant and that information would be encrypted.
- Jim Thur raised concerns about DMAS reimbursements to private providers. His major private provider has been told by DMAS that its payments will be capped at 40 percent. Shirley noted that DMAS has approval to cap private provider reimbursements, but CSBs are exempt from the caps. She said that the Department is attempting to discuss this issue with DMAS.
- Jim Thur asked how the state could penalize private providers in this way. Shirley responded that DMAS feels it is responsible for covering medical, but not natural environment, costs. He noted that this is a huge issue across the services system.
- Ray Ratke asked about a mechanism to obtain coverage for non-medical costs. Shirley replied that we are working on this, but DMAS claims it does not have to pay for natural environment costs, even though the federal Department of Education (DOE) requires providing services in this environment. She indicated that the Department has made the federal DOE aware of this to see what can be done at that level.
- George Pratt asked what the Department could do about this. Dr. Reinhard said he could raise the issue of the private provider reimbursement cap at the agency heads meeting.

3. FY 2005 Performance Contract Data Requirements

- Paul Gilding reviewed this subject, which was continued from the last Council meeting.
- George Pratt indicated that he had been reviewing the VACSB committee structure to identify the responsibilities of various committees. The VACSB's intent is for the existing Performance Contract Committee, chaired by Candi Waller, to continue working on this topic. She has sent an e-mail to start the process.

4. Community Consumer Submission (CCS) Update

- Grace Sheu updated the Council on the CCS. Eighteen CSBs use CMHC. Eddie Roadcap, from the Harrisonburg-Rockingham CSB and a CCS pilot, reported at the last CMHC user group meeting that the CCS extract file was very simple to use, simpler than SCADS. Seven CSBs use Anasazi, and many of these are large CSBs. Colonial is the pilot CSB for Anasazi; its staff has provided a very complete and detailed set of specifications for Anasazi to develop an extract program. Six CSBs use BTI; Crossroads is the pilot CSB for this system. The remaining nine CSBs use a variety of other systems (e.g., CSM, Medical Manager).

- Grace thanked the VACSB Data Management Committee and the Department's Data Policy Task Force for their hard work in developing the CCS.
- The Council discussed using all or some of the $1.4 million in federal mental health block grant savings from the State Pharmacy to assist CSBs in implementing the CCS. Joy Yeh reminded the group that this money was one-time savings. The Council decided to discuss use of the savings at its next meeting.

5. MR Waiver Slot Management

- Martha Adams discussed management of slots for the Medicaid Mental Retardation Home and Community-Based Waiver. She noted that a number of slots appear to be held for longer than permitted by Medicaid regulations. Some slots have been vacant for a year.
- Since some new slots have been provided, there may be more attention focused on how current slots are managed. Therefore, the system needs to adhere to the regulations. A slot can be held for 60 days, with one 30-day extension approved by the Office of Mental Retardation Services.
- In response to a question, she indicated that the Department's web site contains information by CSB about numbers of active slots, slots assigned, and slots held open and about numbers of persons on the urgent and non-urgent waiting lists. She noted that the VACSB MR Council discusses this information regularly. She stated that the web site information did not include the amount of time slots were held open. Council members suggested this would be helpful.
- In response to another question, Martha replied that holding slots open for long periods was widespread, but CSBs had good reasons to hold slots open in most situations. Ray Ratke suggested that perhaps some rules needed to be changed. Martha responded that now slots can be held open for four months (the original 60 days, a 30 day extension, and a 30 day appeal period if the slot is terminated).
- George Pratt suggested that the Executive Directors Forum be asked to monitor CSB practices about holding slots open. He noted that it might be helpful for every CSB to see information about all 40 CSBs. Frank Tetrick agreed to place this topic on the July 22 Forum agenda, and Martha agreed to provide the necessary information to him.
- Dr. Reinhard suggested that the Restructuring Policy Advisory Committee might discuss this topic and asked Martha to raise it at the Committee's next meeting. Charline Davidson asked that, along with the numbers, some analysis of the reasons for holding slots open be provided, since otherwise there could be some unintended consequences. She noted that the issue is more complicated than just the number of slots and how long they have been held open.
- Frank Tetrick recommended that later at some point families and advocacy groups be involved in the discussion, because their decisions affect the issue. He suggested that, once we have enough information, we might need to look at tightening the criteria for holding slots open for extended periods. Judy Dudley stated that state facilities and CSBs need to do everything possible to keep consumers in slots.
- In response to a question, Martha Adams indicated that 72 out of 5,711 slots were open more than six months. Jim Stewart said this put the issue in a different perspective and suggested that, because the issue is important, explanations for those 72 slots be developed, grouped by type of explanation. This would allow us to target efforts to address the issue. Charline Davidson recommended also including slots with no billing activity. Martha Adams indicated this would be an additional 200 slots.
- Martha Adams agreed to e-mail to Executive Directors lists by CSB of consumers whose slots have been held open with the reasons they have been held open and of consumers with no billing activity.

6. Olmstead Task Force Update

- Julie Stanley updated Council members on the Olmstead Task Force Report. She indicated that the Task Force would like to eliminate waiting lists by 2009.
- The Task Force will hold its final meeting on July 28. Subsequently, this was changed to August 28. Last week, it adopted its final draft report, which will be distributed for public comment between June 20 and July 18. The issues teams will continue meeting to review public comment and make recommendations to the Task Force Steering Committee.
- The Steering Committee will meet on
  - □ July 14 to develop an executive summary, and
  - □ July 21 to consider public comments and changes to the report.
- Julie mentioned that the final draft is 550 pages long, but the appendices are not being distributed with the paper copies (they are on the web site and available on request). She focused on Appendix B with the Council. This contains all population and service information and descriptive analyses of the consumer and family survey form, of which there were 370 responses as of May 20, and the facility survey. Staff are assembling the results of the third survey, of parents and guardians of state training center residents, to which there was a 48 percent response rate.
- In reviewing the draft, Charline Davidson urged members to look at Appendix B for mental health, mental retardation, and substance abuse services and at the recommendations regarding responsible agencies and time frames. The appendix contains preliminary Comprehensive State Plan data. She noted that the Olmstead Report will have implications for our work.

7. Licensing and Human Rights Regulation Work Group

- Julie Stanley informed Council members that the first meeting is scheduled for July 1. Joe Hubbard will present the results of the VACSB's survey about these issues.
- She indicated that the group will address the issue of interpretive guidelines, which came up at the Executive Directors Forum in May, in the context of the survey results.

8. HPR IV Census Management Plan

- Larry Latham reported that the first phase of HPR IV's reinvestment plan has been completed. The civil census at Central State Hospital (CSH) is down to 120 beds, with five of those beds available at all times. The next phase will be to reduce the census to 100 beds by September, with the five-bed cushion. He noted that, in a typical month, CSH receives 10 civil admissions.
- The Regional Authorization Committee of the HPR IV Pilot Project meets weekly and will monitor the use of those beds. He indicated that the Committee, the key part of the Pilot Project, had been so successful over the past three years that the region decided to give it the task of managing the CSH census.
- There is an agreement to manage the census. Whenever the census rises to 115 beds, the Committee identifies patients to be discharged who are ready to leave in order to keep the census at 115. Jim Stewart indicated that CSH does not decide a patient should leave, the Committee decides. This is the key to its success.
- George Pratt expressed a concern that this approach sounded arbitrary. Jim Stewart emphasized that the patients on the list have already been identified as ready for discharge. The Committee's decision only focuses more attention on efforts to discharge them. The region has agreed on a cap on the CSH census; this enabled removing funds from the hospital budget. It means the region has to manage the hospital's census that much more tightly.

- HPR V Executive Directors agreed that this approach, depending on how it was framed or described, could jeopardize their region's reinvestment project. It was suggested that the HPR IV approach sounded like phase two of HPR V's reinvestment proposal.
- Jim Stewart noted that HPR IV collects a lot of information tied to the project, no one complains about it, and the data is pretty accurate. Based on that experience, he suggested that we should identify the data needed to manage a program and then look at internal data to see how the two perspectives mesh. How do we blend the information needed to manage the program with external reporting requirements? He offered this as a perspective for developing the FY 2005 performance contract.
- Ray Ratke noted that part of this discussion came about from identifying the need in each region for a contingency plan when the state facility serving the region reached its capacity. HPR IV seemed to be a useful model for other regions. However, this might not be the best protocol or approach for every region.
- Jim Stewart cautioned that HPR IV's success grew out of three or four years of work on the Acute Care Pilot Project; the region could not have achieved its census management success four years ago.
- Dr. Reinhard observed that this was an important discussion from a philosophical perspective involving two assumptions. First, is there an unlimited supply of state hospital beds? HPR IV would appear to answer no; HPR V would seem to answer yes. Second, is there some real science in determining a patient's readiness for discharge? Jim Stewart concurred with his points – there is a limited supply of beds and there is no science about discharge readiness.
- Ray Ratke observed that HPR IV recognizes that the CSBs and state facility are responsible for managing the CSH census, while recognizing that the number of beds may need to be larger. However, the results of their census management efforts will document this need. The Region IV Acute Care Pilot Project has better identified the real number of total inpatient bed needed by the region. Jim Stewart noted that the use of HPR IV's inpatient beds by consumers from other regions has complicated the project. He suggested that some state level guidance on this issue would be helpful.
- Larry Latham pointed out that, while everyone agreed on the cap of 100 beds, CSH has agreed to take temporary detention orders (TDOs) if no other beds are available. He indicated that the Regional Authorization Committee is the hardest working group he has seen. He suggested it would be helpful for other CSBs to observe the Committee's work. It meets three to four hours per week. John Dool's data is crucial. Out of 10 admissions per month, only three really need admission to CSH, the other six or seven are admitted due to lack of local beds.
- Dr. Reinhard asked if there would be agreement that the other regions are not where HPR IV is now. George Pratt and Frank Tetrick agreed that HPR V was not, but suggested that their region (CSBs and Eastern State Hospital) could benefit from dialogue with HPR IV and perhaps from importing its methodology. Lynn Chenault indicated that HPR III also was not at the same place as HPR IV.
- Dr. Reinhard suggested that CSBs accept that state facilities will take TDOs if necessary and recognize that discharge decisions are a matter of judgment rather than science. He asked what our next steps should be to address state facility census management.
- Ray Ratke reflected that, originally, disseminating the HPR IV approach seemed as if it could provide a good model; but, perhaps this might not be helpful. He suggested developing some ideas about state facility census management (e.g., when you need a bed, who do you call?) and circulating them to the regional chairs. Larry Latham cautioned that we need to deal with concerns within the state facilities about discharge processes and issues.

- Dr. Reinhard noted that we are moving forward through reinvestment in different ways in the various regions. Rather than focusing on rigid rules, we need to work together on state facility census management, using data about utilization. George Pratt suggested that such data include information about why patients were not being discharged.
- Ray Ratke observed that HPR IV has worked out how to deal with its situation when its state facility is at capacity; ultimately, the other regions need to do the same. Jim Stewart suggested such protocols would be most successful when they come from within the regions.
- Charline Davidson urged that the expectation be stated that regions will develop census management protocols. Lynn Chenault agreed that requiring protocols without mandating their content is appropriate. This appeared to be the consensus of Council members.

9. Discharge Protocols Work Group

- George Pratt noted that CSB Executive Directors had suggested convening the group that originally developed the protocols to assess how well they have worked. He indicated that Frank Tetrick will identify VACSB representatives to serve on this group.
- George Pratt recommended that the group identify ways to make the protocols more efficient. The group should review the protocols themselves and the process by which they operate. He suggested that this need not be a long, drawn out activity.

10. Reinvestment Project and Regional Restructuring Partnership Updates

- Jim Thur observed that the discussion on state facility census management provided a good segue to this topic. He suggested that, while all of the comments from the communities and regions are correct, a little impetus from the Commissioner or state facility director helps.
- He noted that HPR II's experience is different. Because of the situation at the Northern Virginia Mental Health Institute (NVMHI), with only 90 civil beds (after excluding forensic patients) for a population of 2,000,000 people, the region has to go to the private sector for its safety net. Admissions have fluctuated from eight to 52 per month, and it is impossible to be able to tell private providers how they should staff up to meet this demand. He indicated that the $1.9 million of DAD funds is migrating from NVMHI to the CSBs. The eight private hospitals are meeting with the region's CSBs and NVMHI, and we want to continue talking.
- He discussed HPR I issues, with more stress on Western State Hospital's capacity and the growth of the forensic population, which is primarily in HPR I rather than HPR II. As a result, there are more people with mental illnesses in jails than in state facilities. He suggested this may jeopardize the HPR I reinvestment project.
- He indicated that everyone is at the table in HPR II, and planning has shifted from CSB-specific to regional efforts. Reinvestment funds are in a common pot, and the DAD funds are moving into it, which should help. He also noted that the Central Office has been very responsive.
- Dr. Reinhard concurred that the forensic population is definitely an issue. Jim Thur noted that many rural jails are 100 percent over capacity, so they are happy to send their inmates to state facilities. Thus, sending mental health staff into the jails may not help.
- Jim Thur suggested we need to move to a regional focus rather than an individual CSB focus in managing state facility census. George Pratt observed that his clinicians do not send patients to Eastern State Hospital; all patients are sent there by judges and independent psychiatrists.

11. Restructuring Policy Advisory Committee (RPAC)

- The RPAC will bring together regional leadership and key advocates to address statewide issues. About 60 individuals have been invited to the first meeting, including consumers,

advocates, Central Office staff, CSB representatives, state facility directors, private providers, DMAS, the Department of Planning and Budget, and the Inspector General.

- The RPAC's first focus will be addressing specific populations (e.g., forensic, child and adolescent, mental retardation, substance abuse, gero-psychiatric). However, it also will address other issues.

12. SVP Program Update

- Dr. Reinhard discussed this program, which will be the Department's 16th state facility. He noted that Jerry Deans has been the lead on implementing this program. In the next few weeks, the Department will be hiring staff.
- George Pratt asked if there was any estimate on the census over the next 12 months. Dr. Reinhard responded that it could be up to 25 patients. Ray Ratke indicated that six or seven people who might be admitted are moving through the process now. Martha Mead said that the first admission might be in August.
- George Pratt asked what the CSB responsibility for such patients would be. Jim Thur suggested that CSBs had no responsibility. Martha Mead indicated that the Department would be responsible for conditional releases of these patients. The Department is discussing with the Department of Corrections whether Probation and Parole could monitor conditionally released patients. Ray Ratke noted that two people have already been recommended for conditional release rather than for admission to the SVP program.

13. Paperwork/Record Keeping Requirements Reductions

- George Pratt noted that the VACSB was going to establish a group to work on this through the Administration Committee. Jim Stewart expressed the hope that a lot of leadership on this will come from the Department.
- Dr. Reinhard asked how this differed from the Licensing and Human Rights Regulations Work Group. Jim Stewart clarified that the paperwork/record keeping activity should be a bottom-up and top-down effort to look at requirements and their demands on clinical staff and at the implications for service delivery. He indicated this was not a data elements issue, but a clinical documentation and record keeping issue.
- George Pratt noted that the Licensing and Human Rights Regulation Work Group will look at issues for upcoming regulatory reviews, while the paperwork and record keeping activity needs to look at how we do business now. He observed that part of this issue may be what CSBs do to themselves in their efforts to comply with requirements.
- Jim Stewart noted that requirements may evolve from two sources: first, what the regulations or standards require; and second, the interpretations of licensing or DMAS reviewers. George Pratt suggested the need to develop interpretive guidelines because different reviewers do not always interpret the human rights or licensing regulations consistently.
- Jim Stewart identified three different tasks that need to be accomplished separately:
  - □ conflicts between the human rights and licensing regulations,
  - □ too much time spent documenting (as high as 40-50 percent of clinical time, which is unacceptable), and
  - □ sharing information about how to improve things.

  He suggested a goal of lowering documentation time to 20 percent by 2007.
- Dr. Reinhard observed that some of this may be driven by individual clinician needs or perceptions about protecting themselves legally. Julie Stanley noted that licensing staff

mentions tremendous variations in how providers keep records, all of which comply with the regulations, but some of which seem inefficient and burdensome.

- Jim Stewart asked if there are changes we can make in requirements and are there more efficient ways to keep records? He suggested a two-phased approach: assessing the problem and identifying solutions.
- Frank Tetrick proposed two representatives from the VACSB, not necessarily Executive Directors, meet with licensing staff and DMAS representatives to define the problem.
- George Pratt noted that the real focus is efficiency. Some CSBs are doing it better than others, but no one is doing it really well. Jim Stewart cautioned that we do not want to meet nonsensical requirements efficiently.
- Jim Stewart supported Frank Tetrick's proposal, suggesting the Deputy or an Assistant Commissioner be the Department's point person, plus two CSB representatives, one licensing staff, and one DMAS utilization review staff. Dr. Reinhard suggested focusing on the community first. There was a general consensus among Council members on this approach. Dr. Reinhard agreed to assign a lead person.

14. FY 2004 Performance Contract Areas for Future Resolution

- The Council agreed that the FY 2005 performance contract committee should discuss how to address the areas for future resolution in section 10 of the FY 2004 contract.

15. Next Meeting: The Council's next meeting is scheduled at 9:00 a.m. on August 11. Future meetings are tentatively scheduled on September 29 and November 10, 2003. All meetings will be held in Conference Room C at the Henrico Area MH & R Services Board. Subsequently, the August 11 meeting was rescheduled to August 25 and then cancelled. As a result, the next meeting of the Council will be on September 29.